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ABSTRACT

These symposium papers describe various aspects of the Camp Logan, South Carolina, program, a therapeutic summer residential program for children, ages 8-14, who have significant behavior problems. The philosophy and advantages of the therapeutic camping model are discussed, e.g., structure during the summer, controlled though informal naturalistic environment, and positive orientation. The liaison between community mental health centers and the camp program is presented, with emphasis on the therapeutic benefits to the child of a comprehensive treatment approach. Linkages between family, agency, and campers, such as visits, reports, letters, and family activities are described. Staff training is discussed in a paper focusing on basic principles of the therapeutic model, its psychological assumptions, and specific skill training in the application of behavior and learning theory and in traditional camping skills. The contigency management program, focusing on specific target categories (self-help, peer relations, compliance, and program participation) and the camp's token economy system and reinforcers are described. Illustrations of innovative treatment applications, both in individual and group modalities, are offered including the case of a borderline psychotic child with deficits in all target categories, and the case of a child with noncompliant, aggressive behavior. Therapeutic applications in specific activities (swimming, camping, and recreation) are also presented. The papers conclude with an evaluation of the program including three case studies. Results indicate that Camp Logan is an effective intervention for behaviorally disturbed children, with 85% of the campers showing improvement. (BL)

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Summer Camp as Therapeutic Context:

The Camp Logan Program

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Symposium presented at the 29th Annual Meeting

of the Southeastern Psychological Association,

March 24, 1983, Atlanta, Ga.

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Abstract

This document describes a symposium presented to disseminate information about Camp Logan, a therapeutic summer camp for children with significant behavior problems. Specialists in various aspects of camp operations presented the following topics: philosophy and advantages of the therapeutic camping model, liaison between community mental health centers and the camp program, staff training, the contingency management system, innovative treatment applications, therapeutic applications in specific activity areas and evaluation of the camp program.

Summer Camp as Therapeutic Context: The Camp Logan Program

Camp Logan is a therapeutic summer camp for children from ages 8 to 14 with significant behavior problems. The camp program supports and assists treatment provided by the state's community mental health centers. The Division of Community Mental Health Services of the South Carolina Department of Mental Health directs camp operations. The programs and activities at Camp Logan are carried out by counselors and specialized staff under the supervision of psychologists and psychology graduate students. The counselors are carefully selected through a personal interviewing process and consist mainly of students from colleges and universities in the Southeast. The therapeutic value of the six to eight week camp experience for the approximately 48 campers is enhanced by the high ratio of one staff member to each two campers. The specialty staff includes a full-time nurse, waterfront director, overnight camping director, recreation coordinator and camp administrator.

Camp Logan provides a model of an effective and innovative program within the context of a state mental health system. In a review of literature on therapeutic camping, Byers (1979) concluded there was a need for documentation of the actual content of therapeutic camping programs as well as evaluation of their outcome. The following symposium presented a comprehensive overview of the Camp Logan program with a description of its therapeutic elements, addressing various levels of intervention (e.g., camper, family, mental health system), and evaluation of program effectiveness.

The objective of the symposium was to disseminate information about the Camp Logan program by offering perspectives from specialists in various

aspects of camp operations. This was accomplished by assembling symposium presenters drawn from the directors' staffs at Camp Logan over the past six years.

Participants and topics consisted of the following:

William A. Roberts, Virginia Treatment Center for Children
Overview of Therapeutic Camping

Susan McCammon, East Carolina
Camp/Mental Health Center Liaison: Linking Camp and Local Systems

Jean Ann Golden, East Carolina University
Staff Training: Basic Principles and Specific Skills

Charles Gibbs, University of South Carolina
Contingency Management: The Point System Component of a Residential Summer Camp

E. Wayne Holden, University of South Carolina
Innovative Treatment Applications in a Therapeutic Camp

Michael R. McCammon, East Carolina University
Therapeutic Applications in Specific Activity Areas

William A. Roberts, Virginia Treatment Center for Children
Evaluation of the Camp Logan Program

PHILOSOPHY AND ADVANTAGES OF A
THERAPEUTIC CAMPING PROGRAM

Summer camps for emotionally disturbed children are a fairly recent and innovative therapeutic development. What follows is the philosophy and what we consider to be the advantages of one particular therapeutic summer camp. Camp Logan is a therapeutic summer camp which provides a therapeutic as well as recreational experience for emotionally disturbed children. In the development of the camp program it had become clear to many of us that we have closely adhered to some principles while experimenting with programmatic changes dictating how these principles are applied in the daily functions of the camp. Outlined below are some of these principles:

1.) Insight is a by-product of experience. It is our belief that individuals mature and develop by doing. At camp children are shown new skills, encouraged to try new behaviors, and given corrective feedback. The development of competency skills (e.g., problem solving, social skill development) are encouraged over the remediation of problem behaviors and children are encouraged to engage in success oriented activities as opposed to competitive activities. For example, we would never encourage one cabin group to compete with another cabin group to see who could have the cleanest cabin at camp. Instead, each cabin group would have goals developed specifically for them and their level of "cleanup" skills. They would "compete" against their performance of the previous day, encouraged to improve their skills while provided with information assessing their strengths and weaknesses as cabin cleaners. Finally, they would be rewarded for success as they improve on their skill.

2.) The basic principles of behavior modification, namely the manipulation of antecedants and consequences to alter behavior, are useful in helping children develop new patterns of behavior. Although the camp personnel are familiar with, and use, other forms of therapeutic interventions from various theoretical perspectives, behavior modification techniques are central to the core child management program. Two behavioral programs occur simultaneously. One program is based on a child's skill development in accord with an individually tailored treatment program. The other program is based on each cabin group's performance and utilizes group contingencies.

3.) Treatment is ongoing and can be provided by all staff in all contexts. While a child is at camp, differentiation is not made between recreational activities and therapy time. Ideally, both are done always. Staff attempt, however, to give the therapeutic value of an activity, priority over its recreational value. For example, during an activity such as canoeing, emphasis is placed on group and interpersonal cooperation skills, compliance, and increased self esteem through the development of new skills. Also, all staff are trained in behavioral management techniques and supervised by at least Ph.D. canidates who are themselves familiar with the camp program, the campers, and the camp counselors.

4.) Staff development occurs in much the same way that the children at camp (i.e., campers) grow and mature. That manner of growth is characterized by "doing" in a supervised setting and receiving feedback. Our experience each summer is that members of our college aged paraprofessional counselor staff, who have primary direct child care responsibilities, experience as much personal growth as do our campers.

5.) The camp program is part of an ongoing community mental health center program. Children who attend camp are selected from referrals made by community mental health centers. These children are children who, along with their family, have been involved in therapy at their local mental health center. While the child is at camp, camp staff communicate with the local mental health center therapist who in turn has weekly meetings with their campers' parents. Once camp is over, camp staff provide feedback to the mental health center therapist and the child and family continue their involvement with their local mental health center.

Given Camp Logan's philosophy and its program, which has emerged from several summers of camp work, there seems to be several advantages that we feel the camp enjoys. The following outline highlights some of these advantages.

1.) Generally, when one thinks of an advantage, one thinks comparatively (i.e., advantageous as compared to what?). In our area of the nation, community mental health centers generally report a decrease in the delivery of child services during the summer months. Whatever the reasons are for this phenomenon, its reality means that for many children a therapeutic summer camp is an alternative to no therapeutic involvement. Therapeutic involvement during the summer is helpful in that besides all the benefits of involvement during the remainder of the year, it also provides some structure for children during a time when structure is often minimal because there is no school in session.

2.) Camp Logan provides a controlled living situation for emotionally disturbed children while avoiding the stigma and cost of hospitalization.

Many of the children Camp Logan has worked with historically have been children who are similar to hospitalized children with respect to severity of disturbance as well as type of probems they were encountering. Our experience is that for some children a summer at Camp Logan prevented a possible subsequent hospital stay, while for other children, their summer at camp replaced a probable hospitalization.

3.) Camp Logan provides an environment which has the potential for close naturalistic observation and assessment. For many children who are clients of a community mental health center, their contact with a therapist is limited to, at most, a few contacts each week. These contacts are most often in the context of the mental health therapist office. Information available to the therapist is therefore limited to parental report, the child'sself report, and what is observed in the office. While at camp, children are observed participating in daily living situations which facilitates a more comprehensive assessment.

4.) Camp Logan also provides a setting in which a therapeutic intervention can be made in the childs natural living situation at the moment of the occurence of the behavior. For example, a child who displays a positive behavior (e.g., sharing a toy) on the school playground may go unnoticed. Ideally, while at camp, that behavior would be observed by the child's camp counselor and the child would immediately be given positive feedback and a social reinforcer such as praise. The same holds true for the intervention with and consequences of problem behavior.

5.) Camp Logan exposes children to success oriented activities. Most emotionally disturbed children experience a high rate of failure in activities typically related to school, home, and/or community life. Oftentimes these failure experiences are the source of a child's participation in antisocial activities. Through the use of cooperative activities and noncompetitive sports, children are placed in a setting in which the opportunity for success is increased and success, no matter how minimal, is reinforced.

6.) Camp Logan, although structured, provides an informal atmosphere in which the necessarily rigid structure of a formal setting such as school is minimized. As a result, children have a greater opportunity to engage in intense motor activities or to take time to work on a specific task until they have mastered it.

7.) Camp Logan provides a setting in which natural consequences can occur. For example, parents are understandably hesitant to allow a child who is habitually and intentionally slow at completing his or her daily morning routine, to be late for school. Instead, the parents attempt other means to hurry the child along since being tardy for school, and eventually being penalized by the school system for lateness, seems to be a consequence parents should help their child avoid. At camp, however, this same child would be allowed to suffer the natural consequences of being intentionally late. He or she would no doubt have to sit on the bank of the lake with a counselor and wait for his or her group to return from the canoe trip which was missed, because of being late. Our experience is that natural consequences are often the most effective ones since there is a direct and often immediate

connection between the behavior and the consequence. Also, since the consequence is a natural result of the child's behavior and not imposed on him or her by someone else, the child has no one to legitimately direct his or her anger at but him or herself.

Summarizing, therapeutic summer camps, such as Camp Logan, are a viable and innovative treatment modality. They have the potential to provide a quality service at a comparatively low cost and enjoy several advantages over other therapeutic interventions.

Camp/CMHC Liaison: Linking Camp and Local Systems

In order to insure that attending Camp is not an isolated experience in a child's life, the Camp Logan program has heavily emphasized its linkage with the community mental health centers (CMHC). We feel that the impact of the Camp experience is greatest, or to use Emory Cowen's metaphor -- we get more miles from our mental health gallons, when a child's attending Camp is a part of a comprehensive treatment approach, involving the important components of the child's ecology.

CMHC Liaison

The central person in accomplishing the connection between the Camp program and the CMHC is the liaison person (CMHC Liaison), who is a member of the local center's staff. Unfortunately, the responsibilities of performing this role is typically in addition to the staff member's regular load. We have been fortunate in finding many staff members who are great advocates of our Camp program and who have devoted many hours and much energy to their Liaison role.

The CMHC Liaison collects Camp referrals from the Center and sends them to the Camp Director. Once campers are selected, the liaison advises therapists at the Center which referrals were selected and distributes information and paperwork, such as behavior checklists for the therapists, parents and when possible, teachers.

Pre-Camp Visit

In the weeks prior to the start of Camp the CMHC Liaison schedules a pre-camp visit, which is attended by campers, their families and therapists, and members of the Camp Logan Directors Staff. During this

meeting, Camp staff show slides and give an orientation to the Camp program. Questions are answered about activities, clothing needs, etc. Following the orientation, a member of the Camp staff meets separately with each family group. The camper's CMHC therapist is encouraged to attend also. In this conference goals are set with input from the camper, the family and the therapist. All parties sign the therapeutic contract that is developed. In camping seasons before this contracting meeting was used, campers tried to convince Camp counselors they had no right but to provide a purely recreational experience. The contracting process has been helpful in emphasizing the therapeutic aspects of the program and sets the tone for family participation.

Communication During Camp

The CMHC Liaison sees that campers have transportation to and from Camp, and some Liaisons drive a CMHC vehicle to transport campers (and family members who want to ride along). Throughout the Camp period much information is exchanged between Camp Staff and the CMHC Liaison in order to promote understanding of the Camp system and to increase the likelihood that therapeutic gains will continue after the child returns home. This communication is maintained through five processes.

Reports. Each week a written progress report summarizes each camper's achievements and problems. The child's counselor, the Assistant Director who supervises the camper's group, and sometimes specialty staff contribute to the report which is sent to the CMHC Liaison.

Directors staff letters. Along with the weekly Camper progress reports, is sent a letter from the Camp Director and/or Directors Staff. These letters include comments on activities and incidents which have

occurred during the week (each week offers many funny stories) and makes suggestions as to issues that CMHC therapists might discuss with parents (e.g., homesickness, ideas to include in letters to campers, suggestions about handling Visitor's Day, etc.).

Telephone contact. Typically, at least once a week, a member of the Camp Directors Staff calls each CMHC Liaison to elaborate on the written reports, answer questions, seek consultation for current problems, and exchange additional information.

Therapist/CMHC Liaison visits. The CMHC Liaison and the CMHC therapists are encouraged to visit Camp at least once during the session, and therapists from nearby centers visit as often as once a week. Through their visits, they can see firsthand the strategies used by the counselors and the behaviors of the campers. The therapists and liaisons can relate issues at Camp to issues at home and can add to the Camp counselors' background information on the campers.

Parent visits. Finally, the link between home and Camp is maintained through two types of parent visits. One is the "spectator" visit, where two days are set aside mid-Camp for visits from parents and families. Unless special permission is obtained and there is a specified, approved purpose, parent and family visits are limited to one of the Visitor Days. The Camper is able to show off his/her new abilities (e.g., swimming skills) and new friends to the family. Families bring a picnic lunch to share with the Camper. Camp staff and parents discuss progress and plans for the rest of the Camp session.

The other type of parent visit is the "working" visit -- a pre-arranged visit where a parent spends a full day and perhaps an overnight

and follows the Camper through his/her daily routine. The parent observes and can practice implementation of management techniques used by Camp staff.

Parental Activities During Camp

While the child is at Camp, parents are expected to maintain contact and continue involvement through their CMHC. Some Center therapists see the parents in individual or conjoint therapy. In other Centers the CMHC Liaison holds a weekly parent group for all the families of campers from that Center. The groups often include a parent training series on child management, offer support from other parents, and serve as the opportunity to give progress reports about each camper. Year after year, it appears that those centers which have an active parents' program have the greatest success in maintaining the behavioral gains which the children practiced at Camp.

Followup

An assortment of strategies has been employed for following up campers' achievements after they return home. Most years members of the Camp Directors Staff have made a visit to each CMHC to meet with campers, families and therapists several months following the end of Camp. Some CMHC Liaisons periodically arrange "reunions" of campers and their families. These bring positive comments from the participants, and offer an opportunity for followup as well. Finally, various questionnaires and scales have been employed to obtain feedback from CMHC therapists and Liaisons about the Camp program and to gather data on post-Camp behaviors of the children. These studies are described in the paper on Evaluation of the Camp Logan Program.

Staff Training:

Basic Principles and Specific Skills

Staff training consists of conveying the general model and psychological assumptions which are the basis of the Camp Logan approach and teaching specific skills which have been found to be most helpful in working with troubled children. The general model of the Camp Logan treatment approach is based on social learning theory. The underlying assumption is that behavioral and emotional problems are learned in a social context in which maladaptive, inappropriate behavior is modeled and reinforced and significant persons fail to either model, teach or adequately reinforce more adaptive patterns of behavior. Consistent with this model, it is the goal of the Camp Logan approach to set up a therapeutic environment in which children are encouraged to modify their faulty behavior patterns and are provided with adequate instruction and motivation to adopt more acceptable ways of behaving and interacting with others.

In order to be effective in teaching and motivating children to change behavior patterns that they have been functioning with all their lives, counselors at Camp Logan must have an adequate understanding of the principles of social learning and behavior management, as well as sufficient skill in applying these principles to everyday situations that arise when living with children. These two objectives for staff training are fulfilled within a busy ten-day schedule that provides counselors with a vast array of information and experiences.

Information is provided through a series of didactic sessions and lectures from directors staff at Camp Logan as well as from staff at Mental Health and Social Service Agencies within South Carolina. For example, a woman from DSS speaks to the counselors about the psychological effects of child abuse. Counselors learn to apply behavioral principles by practicing observation and behavior change techniques in carrying out their own self-management programs. They also are given the opportunity to role play and practice with each other while receiving instruction and feedback from the directors staff.

In addition to gaining knowledge and skill in the application of behavior and learning theory, counselors must also be able to get along well with others while living in close quarters and dealing with stress. Much of this is experienced by having the counselors and directors staff take an overnight camping trip together. All participants must work together in packing backpacks, hiking, cooking, pitching tents and cleaning up. There is also a lot of fun and camaraderie in swimming, sunning, fishing, eating and telling stories around the campfire.

Counselors must also acquire proficiency in such areas as: camping, canoeing, swimming, game playing and basic survival and life-saving techniques. This is accomplished by having counselors rotate in small groups throughout training sessions in various skill areas provided by the camping director, waterfront director, recreation director and nurse. Again, learning takes place through listening to lectures in combination with practicing and receiving feedback.

Also consistent with the Camp Logan approach, counselors must be able to model and teach some basic competencies in order to provide

campers with opportunities to experience success in their everyday lives. In many ways, Camp Logan counselors encounter a similar experience to campers during their ten days of training prior to the campers' arrival. They develop new competencies, experience success and learn more adaptive ways of behaving and interacting with others. Once the campers arrive, they are better equipped to provide the kind of therapeutic environment that teaches and reinforces more appropriate patterns of behavior.

Contingency Management: The point system component of a residential summer camp

Contingency management essentially involves the contingent presentation and withdrawal of rewards and punishments. This paper will focus on the implementation of such procedures at Camp Logan, a therapeutic summer camp. Emphasis will be placed on delineating specific target categories, followed by a description of these procedures in a token economy system used at the camp. The discussion will conclude with several examples featuring the diversity of applications of contingency management procedures.

It is a frequent comment that clinicians, all too often, focus on the elimination or extinction of maladaptive behavior and ignore the more positive goals of strengthening adaptive behavior that occurs less frequently. Concomitantly, it seems that many parents attend to their children chiefly when they misbehave and not when they are "good". Rather than focusing on the negative aspects of behavior, emphasis should be placed on the teaching of techniques that employ reinforcement rather than punishment. This is the primary objective of contingency management. The usefulness of contingency management at Camp Logan is evident for several reasons. By developing a token

economy system we create an environment in which we maintain considerable control. The needs and desires of the campers then become variables that can be manipulated to achieve desired behavior. Secondly, this system provides us with a convenient method of compiling data, and, finally, by observing and recording specific, clearly defined behavior, we obtain empirical support for the progress or failure of a specific treatment. The major goal of our system is to provide a guide for counselors by which they are continually reminded to praise and reinforce positive behavior. Material reinforcers are simply a starting point with social and intrinsic reinforcement being our ultimate goal.

In order to develop a multimodal treatment approach, four categories have been devised in which specific behaviors are to be modified. This is not an exhaustive list but has proven beneficial in the treatment of emotionally disturbed children. They include: (1) self-help; (2) peer relations; (3) compliance; and (4) program participation. Self-help involves those aspects of a child's life which involve personal hygiene care and daily living skills (e.g. making a bed, brushing teeth, etc.). The ability to establish and maintain interpersonal relations is the major focus in peer relations. Compliance traditionally is a facet of behavior that many parents command of their children and typically centers on getting a child to respond to a request

with little or no prompts. The final aspect of treatment is based on the active social participation of the camper. Each of these categories allows us to tailor the treatment program to meet the needs of the individual camper.

To further understand how contingency management works at Camp Logan, a brief explanation of the point system is needed. Initially, each child is assessed for problematic behaivor in each of the aforementioned categories. As these behaviors are delineated, criteria for rewards are devised. Significant emphasis is placed on the criteria that must be met before a child is rewarded. Too often, children are told what they should not do but also are not provided with acceptable alternative behaviors in which they can engage. Rather than noting what is not to be done, we have found it is better to define positive alternatives to undersired behaviors and establish contingencies for them. Thus, instead of asserting that a child should not fight, we emphasize that he must be helpful to others — a positive and incompatible behavior. Initiation of desired behavior is frequently impaired by a limited behavioral repertiore, necessitating the need of prompting desired behaviors. Typical of behaviorally-oriented programs, techniques such as successive approximation, extinction, and differential reinforcement of other behaviors, to list a few, are commonly employed.

In dissemination of points, each day is divided into 15 one-hour periods. During each hour, an assessment is made to determine whether a camper has accomplished any one or all of the areas of improvement (self-help, compliance, peer-relations, participation program). One point is rewarded each period for which a specific criterion has been met. Subsequently, a camper may earn a total of 60 points (4 areas x 15 hours a day) a day. For instance, a withdrawn child may have to actively participate in group activities with no more than 3 prompts. As the camper becomes more proficient in these areas, the level of the behavior and criteria for reward are gradually increased. All counselors carry two cards on each camper. One card is used to specify the criteria in each area of improvement the camper must meet since criteria are specific to each camper; the other is used for recording accrued points. This method allows consistent recording of behavior as it occurs and assists counselors in their endeavor to concentrate on praising the campers. As a rule of thumb, points are not taken away from a camper. Otherwise, a camper may end up with negative points, especially in the initial phase of the program when minimal points have been accrued. Consider a child who has accomplished his goals in the four areas for the majority of the day and then engages in an inappropriate act. If 30 points are taken away, the child may feel he is being punished for more than just his inappropriate behavior.

The child may believe that his earlier efforts to behave appropriately have gone unrecognized. Consequently, he is apt to lose incentive to accomplish his established criteria. The objective, then is not of eliminating points, but rather the rewarding of points to help the child realize that desirable behaviors are valued much higher than undesirable ones. An exception to this rule arises when a camper is responsible for the loss or damage of another camper's belongings. In this case, the responsible camper is required to pay restitution with his points.

Another method for points to be earned is by group. A group consists of 8 campers of similar age assigned to a cabin. There are two ways in which a group can earn points. A maximum of 5 points is awarded for neatness and orderliness of their cabins, which are inspected every morning. The group may receive a maximum of 3 points by retiring to bed at the designated time and compliance with "quiet" rules.

Daily assessment of the camper's treatment program is an integral part of the contingency management format. Each evening counselors meet with their campers to discuss their progress. The time designated for this discussion is called the "token meeting." This period allows the counselors to give feedback, establish viable short-term goals, and elicit constructive input from campers. Several of the target behaviors are gradually modified during this precedure. The behaviors that are to be incorporated

by the end of summer are: (1) staying with the group; (2) maintaining eye-contact, (3) eliciting questions when prompted; and, (4) eliciting questions unprompted. These behaviors are gradually assimilated into the camper's behavioral repertoire on a weekly basis.

The final component of the Camp Logan token economy system involves the exchange of points for reinforcers. Major considerations include exactly what items or privileges may be exchanged and how often exchanges take place. Each day campers are rewarded with such items as candy, chewing gum or fruit, if the criteria for their token meeting have been accomplished (e.g. maintaining eye-contact). Additionally, they are able to exchange points for similar items of low exchange value. This period is called "Mini-Canteen" since only items of low point value are available. On Saturdays, a "Maxi-Canteen" is held allowing campers to purchase significantly higher point items such as clothes, toys, games, swim gear, etc. During the program, campers learn to settle for reasonable alternative items or delay gratification for more highly desirable ones. Group points can be exchanged for behavior privileges (trips to movies, roller skating, restaurants, and other recreational pleasures). As with tangible reinforcers, the more costly the event, the more group points required to engage in that privilege. Typically, a group has two opportunities during the week to exchange their points for such activities.

It is our intent at Camp Logan to obtain lasting positive changes in behavior that will generalize to new situations, particularly the home. Consequently, as the program nears it's end, we implement fading techniques. This allows parents to employ similar procedures that are less sophisticated.

We have been pleased with the range of behavioral problems that were able to be modified at Camp Logan. The generalization of results has also proven significant. In sum, we have documented this procedure as an excellent method to be employed at therapeutic summer camps.

Innovative Treatment Applications in a Therapeutic Summer Camp

The previous presentations described general issues related to therapeutic summer camping and depicted specific aspects of the Camp Logan program. This may have prompted some thought about the parameters of conducting clinical treatment in a summer camp setting. Rather than dwell on research related to clinical issues, this paper will present illustrations of treatments conducted at Camp Logan during the summer of 1982. Hopefully, this will provide a descriptive perspective of the Camp Logan program. To preserve the anonymity of the clients that were served identifying information will not be presented.

The first example illustrates a specific treatment program that was used with a camper who displayed severe deficits in all four areas of the camp program. This particular child had been diagnosed borderline psychotic by local mental health center staff, was living in a foster home, and attending an EMH class in the public school system. He was being maintained on psychotropic medication when he arrived at camp. Initial impressions indicated a withdrawn and apathetic child who was tall, thin, and weak for his age. His medication was gradually phased out after the first few days of camp which reduced greatly his apparent apathy and increased his activity levels. A particular emphasis in this case was placed on the treatment of severly deficent self help skills. Initial assessment indicated the presence of both diurnal and nocturnal enuresis with diurnal episodes occuring at a frequency of two to three times daily and nocturnal episodes occuring at least once each night.

His enuresis impacted on other treatment areas (most notably peer relations and program participation) as it generated frequent teasing from other campers. Both operant and classical conditioning methods were used to treat this problem. To decrease the frequency of diurnal episodes a daily schedule of bathroom visits with increasing intervals of time between visits was implemented. Social, material, and token reinforcers were earned for complying with the demands of this schedule. By camp's end, diurnal episodes were virtually eliminated and bathroom visits were reduced to three to four times daily. Pad and buzzer treatment a la Mowrer and Mowrer was used to modify nocturnal episodes. In the last three weeks of camp he had ten dry nights for which he earned a special reward prior to departing for home. A concomitant change that resulted from successful development of increased bladder control was greatly reduced teasing which facilitated the establishment of positive peer relationships. The structured twenty four hour treatment environment provided by the camp setting was a fundamental ingredient in the successful comprehensive treatment of his enuresis. Other residential settings capable of providing as comprehensive a treatment would probably leave a stigmatized label on his record (e.g. hospitalization). Outpatient behavioral treatments of enuresis often fail due to inadequate implementation of procedures by parents and other novice behavior modifiers.

The second example illustrates a comprehensive approach used to treat a camper whose deficits were more circumscribed and less severe. This camper was described by local mental health center personnel as noncompliant, implusive, boisterous, and aggressive. [illegible] the school

year prior to her tenure at camp she was suspended several times for fighting. Initial observations indicated that she was attractive, but large for her age. Mental health center reports about her aggression and noncompliance were confirmed. It was determined that impulsivity was a major factor related to both aggression and noncompliance. Developing control over her impulsivity was targeted for change as well as noncompliance and aggression. Initially, counselor prompting was used to increase her awareness of impulsivity during times that she was prone to displaying an impulsive response. Once she began to recognize this deep breathing and self talk methods were combined with counselor prompts to calm her down. Counselor prompts were gradually faded. To increase compliance, she was successively required to stop and listen to commands, repeat commands back to her counselors, respond to commands with a positive statement, and comply with the request. Aggression towards peers was treated by reinforcing prosocial behaviors and using time out. Cognitive processing after aggressive and non-compliant incidents was employed to increase problem solving skills in relation to social situations. By camp's end she had significantly decreased impulsive responses, noncompliance, and boisterous play with peers. Gaining control over impulsivity was an important component skill that facilitated positive responses to treatment programs geared towards noncompliance and aggression.

Group approaches interface well with individual treatment methods within the camp setting. Last summer, I was directly involved with anger control and assertion training groups as a therapist. The anger

control group was conducted according to the treatment protocol developed by Finch and Moss at the Virginia Treatment Center for Children. Sessions were held two to three times per week. Relaxation and self talk skills were introduced initally and practiced separately. Role playing and discussion were used to consolidate these strategies into successful coping mechanisms for individual children. Homework assignments (e.g, self monitoring) between sessions were used to generalize skills from the group context to the general camp setting. Additionally, skills acquired within the group were integrated into individual treatment programs in several cases. This was facilitated by the participation of counselors as cotherapists in group treatment. Assertion training focused on treating both aggressive and withdrawal responses. The analogy of a monster and a mouse were used to highlight these contrasting styles. Discussion and role playing were the primary techniques used for presentation and acquisition of skills. Similar to the anger control group, skills acquired were interfaced with individual treatment programs in several cases. An added benefit of using this approach with a well knit self-contained group of female campers was that campers became more aware of social skills in general and assertion skills specifically. By camp's end they were prompting each other to use more appropriate skills in problematic situations.

It is apparent that the group modality is an efficient treatment strategy in the therapeutic summer camp setting. Initial presentation and acquisition of skills are quickly and efficiently handled within this context. Moreover, group methods interface well with individual treatment programs primarily due to the participation of counselors as

cotherapists and the fact that both treatment modalites occur within the same environmental setting. Groups are composed of those individuals that campers interact with on a daily basis. It is difficult to devise a more effective treatment than role playing and discussing problematic interactions with the particular individuals that you are experiencing difficulty interacting with in your "natural" environment. This is rarely the case in outpatient treatment at a mental health center. Other types of skill based group approaches would seem to be of benefit to the summer camp setting. Social skills and social problem solving groups are two examples worth implementing.

In conclusion, both comprehensive and innovative treatment strategies are possible within the summer camp setting. The constant contact between therapeutic agents and campers results in using mundane day to day experiences therapeutically. The many resources available in this consistent therapeutic environment facilitate the interface between group and individual methods to provide comprehensive and effective treatment.

Therapeutic Applications in Specific Activity Areas

Camp Logan's recreational program gives campers opportunities to acquire new skills in swimming, camping, hiking, canoeing, and cooperative play. A waterfront director, camping specialist, and recreation therapist teach, plan, coordinate, and design recreational programs to meet individual and group needs. Although there is much overlap between programs this paper will describe individual aspects of Camp Logan's swimming, camping and recreation programs.

Swimming

Swimming, by far, is the most popular camp activity. Every week campers spend a minimum of 17 hours swimming. Weekly cabin groups receive three to five hours of instructional swim, and twice a day there is an all-camp free swim. The major objective of the swimming program is to have all campers swimming. On the first day of Camp, campers take a swimming test; depending on ability they are classified as deep or shallow water swimmers. Shallow water swimmers have few if any swimming skills and until they become deep water swimmers they must stay in a roped area. Deep water swimmers can go back and forth from deep to shallow water areas.

Safety is the major concern for the waterfront director. As such it is very important to have all campers swimming, because many off-campus activities include swimming. It is very difficult for counselors to watch swimmers and non-swimmers simultaneously. Teaching swimming to some campers is extremely difficult. Every summer two to three campers are water phobic and to help them overcome their fears, swim instruction has to be creative. This teaching approach may include special reinforcers, or in some cases

cabin groups may help a member overcome his/her fears.

To keep interest in swimming high, campers can earn Red Cross certificates, and for more accomplished swimmers Junior Lifesaving badges can be earned.

Camping

Once a week cabin groups go on an overnight camping trip. Camping, for most, is their least favorite activity, because most have never been camping and are frightened by the prospect of sleeping outside. To reduce their fears and anxieties camping trips are designed to give campers opportunities to learn new skills in hiking and campcraft. Also, to make it more enjoyable campers go to exciting places where there is much to see and do.

The camping program is designed to make campers more self-sufficient. This is accomplished by making them responsible for setting up camp, cooking meals, and clean up. At first, counselors help campers acquire some of the basic skills and gradually give them more responsibility. This system works fairly well because it gives campers a feeling of accomplishment; also, if things don't go too smoothly then it's their problem. For this system to work campers have to learn how to cooperate. Many quickly learn that if they cooperate they eat sooner, have more free time, and receive more counselor attention.

A unique aspect of Camp Logan's camping program is that even on campouts campers are still responsible for their behaviors--this is not a rest time. Groups that exhibit good camping skills have more flexibility in where they can go. Those groups who have trouble cooperating and are loud will camp in more primitive settings until better camping behaviors are learned.

Recreation

Cabin groups receive three to five hours each week with the recreation therapist. During these times groups learn cooperative games, make ice-cream, pick blackberries, watch movies, and generally have a good time. The focus of this program is to offer campers recreational activities designed to improve motor skills and which require cooperation between group members to complete a task. Many of the games taught come from The New Games Book, which emphasizes non-competitive play, where everyone can be a winner. Competitive and sexist games are kept to a minimum.

The recreation therapist also plans and coordinates day outings. These trips can be educational visits to a museum, farm, power plant or they can be recreational activities that include trips to a movie, water slide or skateland. To go on an excursion groups must spend earned Group points; educational activities cost usually less than recreational ones.

The recreation therapist also works with campers individually--identifying those with poor coordination and motor skills. Although not too much can be done during the short camping session, campers who do have problems will receive recommendations for remediation when they return to school.

Summary

The recreational staff plan, coordinate, and instruct activities. They also identify campers who have trouble learning new motor skills and offer ideas and recommendations to parents and teachers. This part of Camp Logan can not be overemphasized because many of the situations campers encounter during an activity parallel situations that occur at school. Campers can learn appropriate ways to deal with these situations while at camp, and we believe there will be some carry-over when they return home.

Evaluation of the Camp Logan Program

It has been reported that the re-admission rate to mental hospitals for children and adolescents more than doubled between 1966 and 1970 (Hughes & Dudley, 1972). To help reverse this and similar out-patient trends, there has been a recent surge of innovative treatment approaches in child services. One such treatment intervention has been therapeutic summer camps (Turner, 1976). As summer camps have increasingly become an integral part of comprehensive mental health programs, research has followed demonstrating their effectiveness in specific areas. Cognitive-emotional behavior of both campers (Nowicki & Barner, 1975) and counselors (Deysach, Ross, & Hiers, 1977) has been examined as well as camper social adjustment (Keller, Deysach, Hiers, Ross, & Moore, 1976; Rickard & Dinoff, 1967; Schneiderman, 1974).

An examination of the literature shows that there is an absence of research demonstrating the overall effectiveness of a therapeutic summer camp program. The purpose of this paper is to relate information intended to evaluate the effect of Camp Logan as the subsequent behavioral and social adjustment of its campers as well as any changes experienced by its staff of college aged para-professionals.

Method

Subjects

Campers and Comparison Group. The subjects of this evaluation were campers residing at Camp Logan during the summer of 1980 (N = 46). In order to contrast any changes made by these children a comparison group was formed. Comparison children were comprised of children who were referred to Camp Logan, but did not attend. Initially, approximately 100 children were referred to Camp Logan from local Mental Health Centers. These children were

divided into pairs "matched" on age, sex, race, and overall level of adjustment based on clinic ratings. Each pair had one of its members randomly selected so that the Camp Logan group was similar to the Comparison group with respect to age, sex, race, and adjustment level.

Counselors. Camp Logan counselors from the staff of '79, '80, and '81 (N = 61) were evaluated before and after camp to see if there were any changes in their attitudes about themselves both personally and professionally. Counselors are college aged para-professionals majoring in psychology, education, social work, criminal justice, and other health service related majors. They represent nine different states and over 20 colleges and universities in the southeast.

Treatment Program

The Camp Logan treatment program is an intensive six-week residential camp for emotionally disturbed children between the ages of 8 and 14. Two-thirds of the campers are male and one-third female. Campers are grouped in cabins of eight same-sex, same-age campers. Three college-age counselors have primary responsibility for the eight campers in their group. A detailed description of the camp treatment program is readily available elsewhere (Roberts, 1982).

Assessment Procedures

Campers and Comparison Group. A battery of tests were administered to children, parents, and Mental Health Staff of the children referred to camp approximately six weeks prior to the start of camp. Since children were randomly assigned to the Camp Group, their measures were not part of the camper selection process. Four to six months after the completion of camp, parents, children, and Mental Health Staff were contacted again and the same battery of tests administered. Below is a summary of each of the tests which

comprised the battery.

1. Self-Control Rating Scale (SCRS). The SCRS developed by Kendall and Wilcox (1979) is a 33-item rating scale that has been demonstrated to be a reliable measure of self-control. Validity has been shown as the SCRS correlates significantly with portions of the Matching Familiar Figures test, Porteus Maze Q Score, and behavioral observations. The SCRS is easily filled out by anyone familiar with the child. Parents (mothers) completed a SCRS on their children both pre and post camp.

2. Walker Problem Behavior Identification Checklist (WPBIC). The WPBIC developed by Walker in 1970 and revised in 1976 is a 50-item checklist which measures five factors of a child's behavior: Acting-Out, Withdrawal, Distractibility, Disturbed Peer Relations, and Immaturity. The WPBIC has been demonstrated to be both a reliable and valid measure of these five factors which coincide nicely with the behavior classes emphasized at Camp Logan. The WPBIC can be completed quickly by individuals aware of the child's behavior. Both parents (mothers) and Mental Health therapists completed a pre and post camp WPBIC on all children.

3. Comprehensive Assessment of Mastery and Problems (camp). The CAMP, developed by Deysach, yields a global measure of a child's mastery in the areas of Self Help Skills, Social Skills with Peers, Relationships with Authority, and Program of Group Skills; as well as targets specific behaviors that the child has mastered, or found problematic, in each of these four areas. The CAMP can be easily filled out, is competency based, and is generally positive in its orientation. The four areas it taps are the same behavior areas that are emphasized at Camp Logan. CAMPs were filled out by parents (mothers) pre and post camp.

4. Children's Action Tendency Scale (CATS). The CATS developed by Deluty (1979) is a self-report measure of aggressiveness, assertiveness, and submissiveness in children. It has been shown to have both good test-retest reliability and internal validity. The CATS correlates with self-esteem measures and social desirability scores, and has been shown to discriminate between hyperaggressives and normals. Children in the Camp group fill out the CATS before camp, after the first week of camp, prior to the last week of camp, and after camp. Children in the Comparison group filled out the CATS both before and after camp.

In addition to the SCRS, WPBIC, and CAMP measures, parents of children who were especially interested had the opportunity to complete two additional measures; the Family Environment Scale (FES) and the Child Behavior Checklist (CBCL). The FES was developed by Moos and his co-workers (1974) to provide a description of inter-personal relationships among family members, values emphasized within the family, and the basic organizational structure of the family. The scale consists of 90 true-false items and has been used extensively in a wide range of settings. The CBCL developed recently by Achenbach (1978) provides a detailed picture of a child's problem behavior.

Counselors. Camp counselors were given two measures prior to the start of camp and then again the last day of camp. These measures were given to assess any changes they may have made during the summer. The first measure used was the Mental Health Interest Inventory (MHII) which asked counselors nine questions which they rated on a 5 point Likert scale (strongly agree to strongly disagree) which assessed their interest in persuing a career as a mental health worker.

The second measure used to assess changes in counselor self perceptions was the Tennessee Self Concept Scale (TSCS) (Fitts, 1965). The TSCS assesses

individuals' perceptions of their self identities, how accepting they are of their self perceptions, and how well those perceptions coincide with their behavior. An individuals self concept is sub-divided into five categories: physical self, moral-ethical self, personal self, family self, and social self. Reliability and validity data as well as norms are available for the TSCS (Fitts, 1965).

Results

Campers and Comparison Group

Information from the scales administered pre and post camp for both the camp and comparison group were combined to measure five general areas of functioning: acting-out, withdrawal, distractibility, peer relations, and immaturity. Data was analyzed using the Statistical Package for Social Sciences (SPSS). Table I lists the percent of children who significantly changed (two tailed T test, $p < .05$) in each of the five areas for both camper and comparison groups.

Table I

	Improved	No Change	Deteriorated
CAMPERS N = 42			
Acting Out	52	48	0
Withdrawal	23	77	0
Distractibility	77	18	5
Peer Relations	67	28	5
Immaturity	67	10	23
COMPARISON GROUP N = 38			
Acting Out	48	52	0
Withdrawal	0	0	100
Distractibility	0	77	23

Peer Relations	25	25	50
Immaturity	72	0	25

Counselors

Mental Health Interest Inventory. Table II contains the results of the MHII. It lists the percent of counselors responding positively (strongly agree or agree) to each of the nine questions asked pre and post camp.

Table II

Percent of positive responses

Counselors '79, '80, & '81 (N = 61)

	PRE	POST
1. I am likely to choose a career in a mental health field after graduation.	33	67
2. I am likely to take more psychology courses before graduation.	62	75
3. I will choose a career which will include working directly with children.	40	82
4. I am likely to do graduate work in some area related to mental health care.	55	75
5. I will be interested in a therapeutic camp job next summer.	22	45
6. I would like to work for the S.C. Dept. of Mental Health in the future.	08	37
7. I took this camp job to help me get an idea of whether I might like this kind of work as a career.	62	67
8. I took this job to help me get experience which might help me move farther into a mental health career.	40	67

9. I took this job to help me see how successful I might be in mental health work. 33 40

Tennessee Self Concept Scale. Table III lists the T scores of counselor self concept sub scales as measured by the TSCS for both pre and post camp measures.

Table III

TSCS T Scores

Counselors '79, '80, & '81 (N = 61)

	PRE	POST	CHANGE
Total TSCS	63	70	+7
Identity	63	68	+5
Self-Satisfaction	61	68	+7
Behavior	59	67	+8
Physical Self	54	68	+14
Moral-Ethical Self	61	66	+5
Personal Self	64	66	+2
Family Self	61	67	+6
Social Self	58	68	+10

Discussion

Camper and Comparison Group

Acting Out. For acting out problems it appears that local Mental Health Centers are just as effective in dealing with this concern as is Camp Logan. In each group approximately half the children displaying acting out problems improved significantly while the rest remained the same. Camp Logan then is just as effective in dealing with acting out as are local Mental Health Centers.

Withdrawal. Approximately one-fourth of the Camp Logan population

improved with respect to withdrawal or social isolation, the remainder stayed the same with respect to this problem. In contrast to this, withdrawal for children not attending camp neither improved, nor stayed the same. In every instance it became a more severe problem. For withdrawal related concerns Camp Logan appears to be an effective intervention.

Distractibility. A little over three-fourths of children attending Camp Logan improved with respect to their attention span, 18 percent remained the same and for five percent of the population, the problem became worse. In contrast, none of the children in the comparison group improved with respect to their attention span while almost one-fourth deteriorated. Camp Logan then appears to be successful in increasing children's attention span.

Peer Relations. Two-thirds of children attending Camp Logan improved in their ability to relate positively to their peers while only five percent deteriorated along this dimension. In contrast, only 25 percent of the comparison group improved while 50 percent deteriorated. Children in the Camp Logan group improved significantly greater in their peer relations than did the comparison group children.

Immaturity. With respect to immaturity children in both Camp and Comparison Groups faired about the same. Three-fourths of both groups improved or stayed the same while approximately one-fourth deteriorated.

It appears as though Camp Logan is as effective as local Mental Health Centers in dealing with behavior problems typically associated with acting out and immaturity while being somewhat more successful with respect to withdrawal, distractibility, and peer relationships. It should be clear that this is not to fault local Mental Health Centers. To emphasize this point it is important to note, for example, that during the six weeks of camp the

average number to Mental Health Centers by the comparison group was 4.3. Children at Camp Logan during that same period of time were in approximately 40 half-hour small group sessions (2 to 3 children), as well as exposed to the daily therapeutic orientation of camp. The small group sessions of Camp Logan alone would equal approximately six months of weekly center visits.

Clearly, a normothetic approach to data analysis loses some of the individualistic changes that occur. For this reason the following case studies are presented to illustrate specific instances of successful therapeutic interventions at Camp Logan.

Case Study #1. This first case study is of a 14 year old white male referred from the Piedmont Mental Health Center. His parents were separated and while he occassionally lived with his father most of his time had been spent in various institutions and foster settings. He had been asked to leave one children's home because of his physical and verbal aggression against both peers and adults. He was a discipline problem in school as well. A major treatment goal for this child was to reduce the aggressive physical and verbal outbursts. The child was, as part of his treatment program, rewarded for behaviors which were noncompatible with verbal and physical aggression. Saying nice things to people, being helpful to others, sharing toys, cooperating in games were all behaviors which his counselors reinforced. When physical fighting occurred, the child was required to sit out of his groups activity and write an incident report which related the facts of the event. This report was then reviewed with the child and alternatives to fighting discussed. Table IV in the appendix shows the reduction of physical and verbal aggress throughout the course of the summer. Follow-up information indicated that this child made a healthy adjustment to a new foster setting and school.

While learning difficulties persisted, acting out physically and verbally occurred in rare instances.

Case Study #2. The second case study involves a 9 year old white female referred from the Charleston Mental Health Center. The major concern on the part of her parents was her constant complaining of body aches, stomach aches, or hurt body parts. It was discovered as part of her assessment that she often complained of physical ailments as a means to avoid tasks she found unpleasant or to gain parental attention. Somatic complaints were ignored by her counselors while she was rewarded for saying she felt good. Interesting enough, little change was observed for the first three weeks of camp. In fact during the day before her parents' visitation, she complained about somatic concerns at her highest rate since camp began. Having worked with the local center parents were prepared to ignore her complaints during their visitation day. In this case camp and center coordination proved extremely beneficial. After a successful visit, in which parents were careful to ignore their daughter's somatic complaints there was a drastic reduction in her complaints. During the last four days of camp no somatic complaints were observed. At follow-up, parents reported that their child was doing well, that somatic complaints had ceased, and that they were very pleased with the help they received from both their local center and camp. Table V in the appendix shows this child's rate of somatic complaints through the course of the summer.

Case Study #3. This final case study is of a 12 year old black male referred from the Waccamau Mental Health Center. This child was first referred to the Center by the local school system who felt that he was becoming more and more withdrawn after his fathers untimely death. Of particular concern for both the child's teachers and parent was that he would often talk to

himself acting somewhat detached from his environment. After a few sessions at the local Mental Health Center the child was referred to Camp Logan with the major treatment goal being the reduction of his talking to himself and an increase in his interacting with others. While at camp, the treatment plan for this child involved ignoring his talking to himself while rewarding him for greeting others. What actually involved meeting others systematically varied so that initially the child only had to say hello to someone but by the end of camp had to conduct a short conversation with the person on his own. Table VI shows the decrease in self-talk along with the increase in greeting others. At follow-up, this child's mother reported that the child rarely talked to himself both at home and school and that in contrast, the child was engaging in appropriate peer and adult social interactions.

In summary, it appears from both the normothetic data analyzed as well as the case studies presented, that Camp Logan is an effective intervention for children experiencing behavioral problems. Summarizing the data presented in Table I across children, as opposed to areas of functioning, it is found that 85% of campers significantly improved while 15% were slightly worse at follow-up. In contrast, of children in the comparison group 50% were functioning at the same level at follow-up and the rest had deteriorated. Another very important note is that while the Camp group was doing much better as a whole, they also had a higher rate of Mental Health Center contact during the four months following camp that did the Comparison group. This illustrates that besides camp being a positive therapeutic intervention for the child directly, it also strengthens the parent - center relationship through the weekly summer parent meetings. Apparently this relationship helps keep the family in therapy. Therefore, although indirectly, Camp Logan helps

facilitate better client - center relationships and helps centers maintain contact with a family larger than families in the comparison group. It is this cooperative effort between camp and local center which generates the most productive change for Mental Health Center clients. Also to note, is the fact that children from centers who do not maintain weekly parental contact during camp do not do near as well at follow-up than those children whose parents have been involved.

Counselors

While the major thrust of Camp Logan over the past decade has been to impact on children experiencing behavioral problems, it has long been recognized by its directors to have a powerful effect on the college-aged paraprofessionals who serve as clinical camp counselors. As a whole the counselors represent a fairly selective group of young men and women, choosen from a large pool of applicants recruited from colleges and universities throughout the southeast.

Mental Health Interest Inventory. The MHII reveals that in general, after the summer camp experience, counselors were more inclined to view themselves as moving towards a career in mental health working directly with children. Also, it might be of interest to point out that while only eight percent of the counselors prior to camp stated that they would like to work for the S.C. Department of Mental Health in the future, 37 percent stated such after their camp experience. It seems then that besides the positive effect camp has on the children who attend it, it also serves as a "recruitment tool" for child mental health services in general and for the S.C. Department of Mental Health specifically.

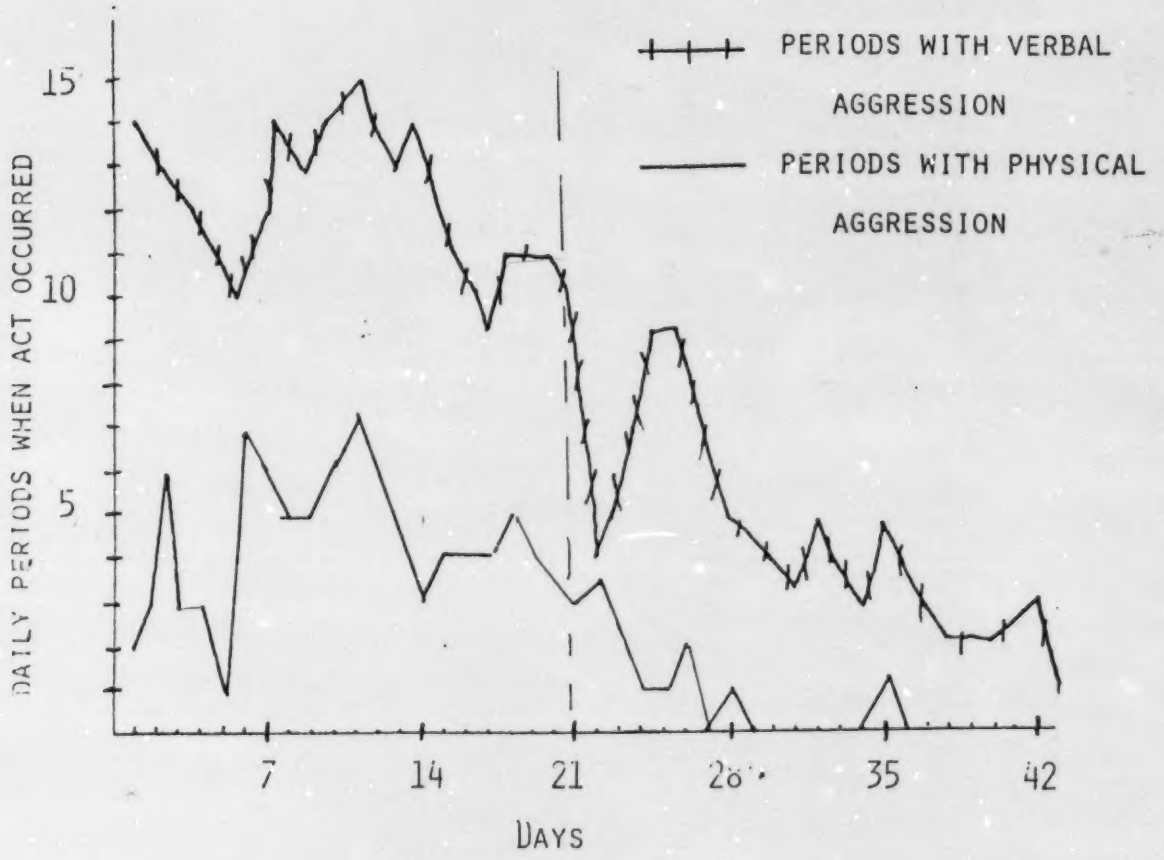
Tennessee Self Concept Scale. On the TSCS post camp scores for counselors are all above the 50th percentile indicating that this group is a

healthy group in general. As indicated in the results session there were increases in T scores on all the scales. The largest increases were for physical and social self. This is understandable given the fact that camp has traditionally been a place where counselors have lost weight, began running, given up smoking, cut down on drinking, etc. Increases in social self concept are probably a result of the intense social interactions that take place as a result of working closely with other staff in a fairly stressful environment.

Conclusion

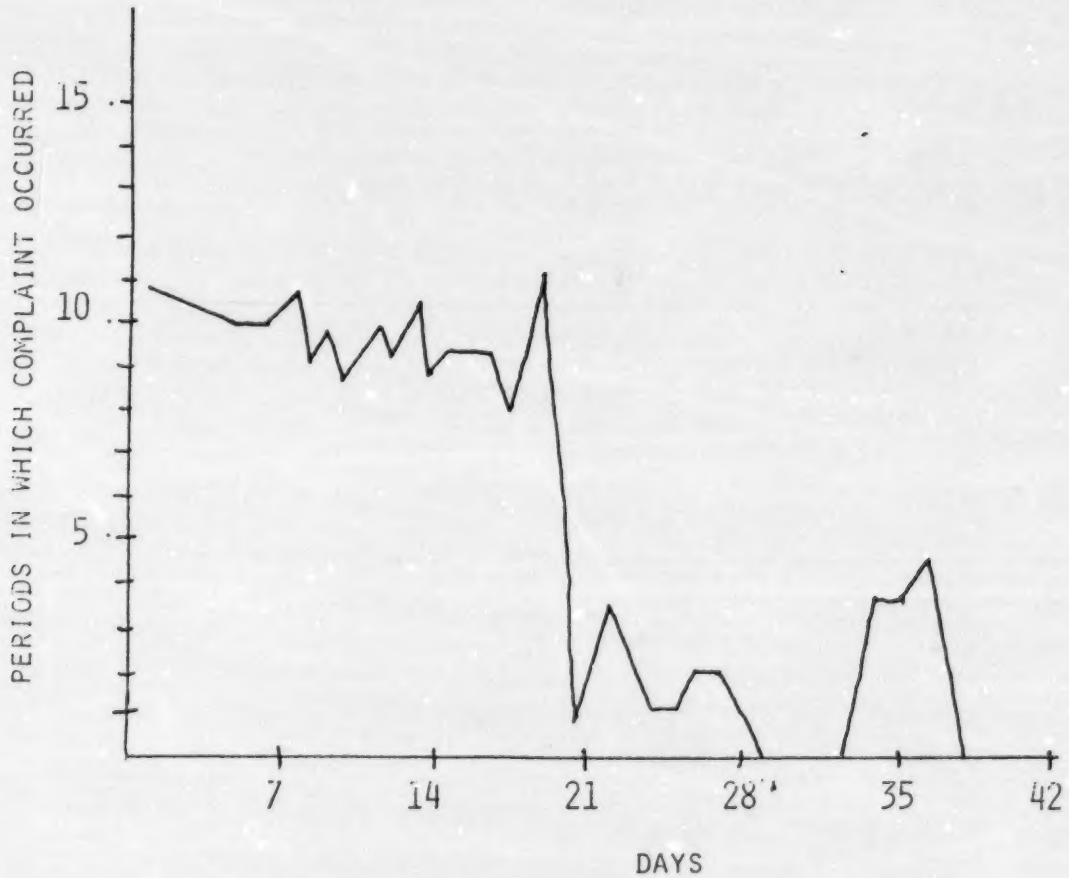
In conclusion Camp Logan is a successful mode of therapy which generates positive changes for children experiencing behavioral problems while facilitating the development of healthy parent - center relationships. It also is an effect tool for developing and recruiting high quality staff for child mental health services in general and for the South Carolina Department of Mental Health specifically.

TABLE IV

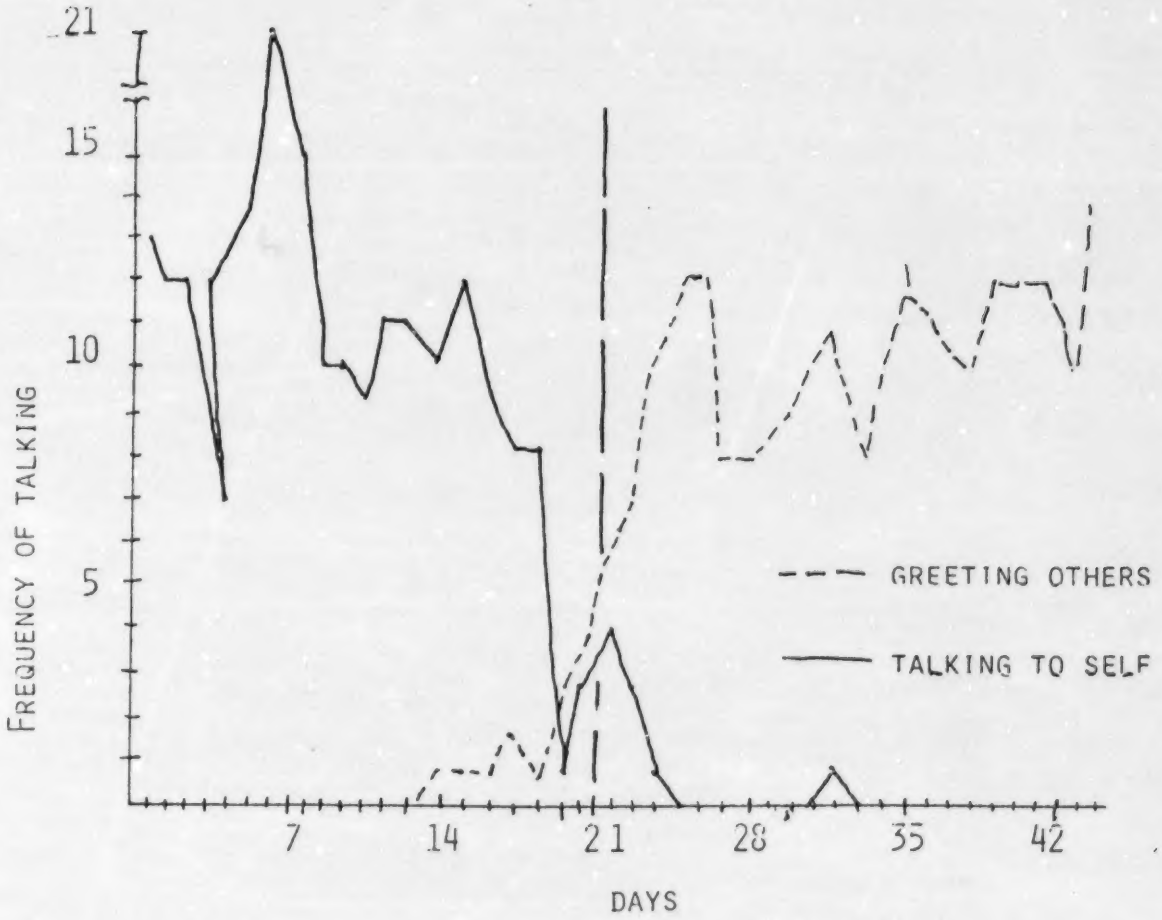


ACTS OF PHYSICAL AND VERBAL AGGRESSION ON THE PART OF A LARGE 14 YEAR OLD MALE CAMPER

TABLE V



SOMATICS COMPLAINTS ON THE PART OF A 9 YEAR OLD FEMALE



INSTANCES OF ASOCIAL AND SOCIAL VERBAL BEHAVIOR IN A 12 YEAR MALE

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